



ZORYVE CREAM (roflumilast) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION	
LAST NAME:	FIRST NAME:
PHONE NUMBER:	DATE OF BIRTH:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
PATIENT INSURANCE ID NUMBER:	

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://magellanrx.com/member/external/commercial/common/doc/en-us/phi-disclosure-authorization.pdf)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page





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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? YES (if yes, complete below) NO

MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:

2. LIST DIAGNOSES: **ICD-10:**

<input type="checkbox"/> Plaque Psoriasis <input type="checkbox"/> Plaque Psoriasis including intertriginous areas <input type="checkbox"/> Moderate to Severe Seborrheic dermatitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
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3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? Yes No

For diagnosis of Psoriasis, please answer the following:

Is the psoriasis affecting 2% - 20% of body surface area? Yes No (documentation required)

Has the patient had a trial and failure to at least two of the following four topical therapies (topical corticosteroid, topical vitamin D analog, topical calcineurin inhibitor, anthralin) Yes No (documentation required for drugs, dates, directions and therapy length)

Is the patient receiving therapy with Otezla (apremilast) tablets or any other systemic immunomodulating agent? Yes No (documentation required if answer is yes)

For diagnosis of Seborrheic dermatitis, please answer the following:

Patient has a diagnosis of moderate or severe seborrheic dermatitis? Yes No Please provide documentation.

Patient has had seborrheic dermatitis for at least 3 months? Yes No Please provide documentation.

Patient has tried at least 3 different topical treatments for seborrheic dermatitis, such as topical steroids, sulfur/sulfacetamide products, antifungals, selenium sulfide products, zinc pyrithione products and/or topical calcineurin inhibitor products? Yes No Please provide documentation with dates of service.

Renewal Information:

Has the member shown improvement in condition over baseline? Yes No (documentation required)

Is the patient receiving therapy with Otezla (apremilast) tablets or any other systemic immunomodulating agent? Yes No (documentation required if answer is yes)





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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

